Step-by-Step Instructions for Completing The Dental Claim Form, 1999 version 2000 For MaineCare Covered Services

Introduction

Please follow these instructions for completing your Dental Claim Form. Please note that these instructions may be filled out using your current software.

The Dental Claim Form 1999 version 2000 is a standard form approved by the American Dental Association. All dental claims submitted to MaineCare must be on this form; we do not accept any other ADA claim forms.

You are responsible for obtaining your own forms; the Maine Department of Health and Human Services (DHHS) does not provide them. You can buy the forms at office supply centers and from other business and medical form suppliers.

Submit only claim forms. Do not submit pre-treatment estimate requests or prior authorization requests with your dental claim.

Send pre-treatment estimate requests and prior authorization requests to:

Prior Authorization Unit
Office of MaineCare Services
442 Civic Center Drive
Augusta, ME 04333

Or Fax to 207-287-7643

Mail your completed Dental Claim Form to:

MaineCare Claims Processing
M-600
Augusta, ME 04333

If your claim is an adjustment claim, mail it to:

MaineCare Adjustments
M-1300
Augusta, ME 04333

Required and Not Required Boxes and Fields

In the following step-by-step instructions for the Dental Claim Form, boxes and fields that are not required are shaded. All required boxes and fields are clear.

Not Required:

BOX 1: DENTIST'S PRETREATMENT

1. ☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services

Not required.

Required:

BOX 42: NAME OF BILLING DENTIST

42. Name of Billing Dentist or Dental Entity

Enter the name of the Billing Provider or providing entity.

Example:

42. Name of Billing Dentist or Dental Entity
John Doe, DDS

Please note, although some boxes are not required, they are also not shaded. This is because DHHS recommends that you enter special information in these boxes.

Examples and Additional Help

The instructions for each required box or field include an example of what the completed box or field should look like. In some boxes that have special instructions for specific providers, there are additional examples.

The instructions also give you important information and help.

Look for these icons:

 ALERT:

 TIP:

Additional Tips on Filing

Here is other important information you need to know before you begin filling out your form:

- Use current American Dental Association (ADA)-approved codes for diagnosis and dental procedures from the Current Dental Terminology Manual (CDT).
- Use the Procedure Codes in Chapter III of the *MaineCare Benefits Manual* policy section under which you bill. You may access these codes at the following website: http://www.maine.gov/sos/cec/rules/10/ch101.htm
- Whether you fill in your claim form by typing, computer, or handwriting, keep all information within the designated boxes. Do not overlap information into other fields.

Instructions for All Boxes and Fields on The ADA Dental Claim Form 1999 version 2000

Boxes 1, 2

BOX 1: DENTIST'S PRETREATMENT

1. ☐ Dentist's pre-treatment estimate Specialty (see backside)
☐ Dentist's statement of actual services

Not required.

BOX 2: MEDICAID CLAIM AND EPSDT

2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT

Not required.

PRIOR AUTHORIZATION

2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT

If the Office of MaineCare Services or another agency issued prior authorization for this procedure, enter the Prior Authorization number.

Do not submit a prior authorization letter or form with this claim.

If this procedure does not need prior authorization, leave this box blank.

Example:

2. ☐ Medicaid Claim Prior Authorization #
☐ EPSDT
050402001

BOX 3: CARRIER NAME

3. Carrier Name

Not required.

BOX 4: CARRIER ADDRESS

4. Carrier Address

Not required.

BOX 5: CITY

5. City

Not required.

BOX 6: STATE

6. State

Not required.

BOX 7: ZIP

7. Zip

Not required.

BOX 8: PATIENT NAME (LAST, FIRST, MIDDLE)

8. Patient Name (Last, First, Middle)

Enter the member's name **exactly** as it appears on his/her MaineCare eligibility card: last name, first name, and middle initial. Include any punctuation that is in the member's name.

Example: O'Neil, Susan J.(apostrophe becomes a space)

8. Patient Name (Last, First, Middle)
O Neil, Susan J.

ALERT:

Enter the member's name exactly as shown on the MaineCare ID Card.

BOX 9: ADDRESS

9. Address

Not required.

BOX 10: CITY

10. City

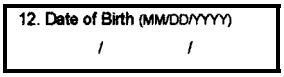
Not required.

BOX 11: STATE

11. State

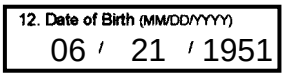
Not required.

BOX 12: DATE OF BIRTH



Enter the month, day and year the member was born in 8 digit format is MMDDYYYY.

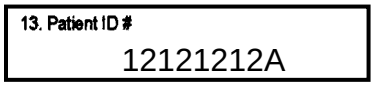
Example:



BOX 13: PATIENT ID

Enter the patient's **MaineCare ID** number **exactly** as shown on his/her MaineCare eligibility card. Do not use dashes or hyphens.

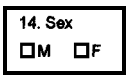
Example:



☞ TIP:

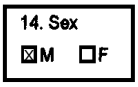
To verify a patient's MaineCare eligibility, use the medical eligibility swipe card system, or the Interactive Voice Response system (IVR) at 1-800-452-4694 or 207-287-3081.

BOX 14: SEX



Enter an X in the appropriate M or F checkbox.

Example:



BOX 15: PHONE NUMBER

15. Phone Number
( )

Not required.

BOX 16: ZIP CODE

16. Zip Code

Not required.

BOX 17: RELATIONSHIP TO SUBSCRIBER/EMPLOYEE

17. Relationship to Subscriber/Employee:
☐Self ☐Spouse ☐Child ☐Other_____

Not required.

BOX 18: EMPLOYER/SCHOOL

18. Employer/School
Name_____ Address_____

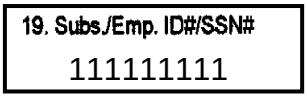
Not required.

Box 19

BOX 19: SUBS./EMP. ID#/SSN#

This box is optional. Use this box to enter patient account information, such as the patient's account number or last name. This information will appear on your remittance advice statement (RA).

Example:



Boxes 20 – 24

BOX 20: EMPLOYER NAME

20. Employer Name

Not required.

BOX 21: GROUP

21. Group #

Not required.

BOX 22: SUBSCRIBER/EMPLOYEE NAME

22. Subscriber/Employee Name (Last, First, Middle)

Not required.

BOX 23: ADDRESS

23. Address

Not required.

BOX 24: PHONE NUMBER

24. Phone Number
( )

Not required.

BOX 25: CITY

25. City

Not required.

BOX 26: STATE

26. State

Not required.

BOX 27: ZIP CODE

27. Zip Code

Not required.

BOX 28: DATE OF BIRTH

28. Date of Birth (MM/DD/YYYY)
/ /

Not required.

BOX 29: MARITAL STATUS

29. Marital Status
☐Married ☐Single ☐Other

Not required.

BOX 30: SEX

30. Sex
☐M ☐F

Not required.

BOX 31: IS PATIENT COVERED BY ANOTHER PLAN?

31. Is Patient covered by another plan
☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical

Not required.

BOX 32: POLICY

32. Policy #

Not required.

ALERT:

Do not put the patient's account number in Box 32.

BOX 33: OTHER SUBSCRIBER'S NAME

33. Other Subscriber's Name

Not required.

BOX 34: DATE OF BIRTH

34. Date of Birth (MM/DD/YYYY)
/ /

Not required.

BOX 35: SEX

35. Sex
☐M ☐F

Not required.

BOX 36: PLAN/PROGRAM NAME

36. Plan/Program Name

Not required.

BOX 37: EMPLOYER/SCHOOL

37. Employer/School
Name_____ Address_____

Not required.

BOX 38: SUBSCRIBER/EMPLOYEE STATUS

38. Subscriber/Employee Status
☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student

Not required.

BOX 39: UNTITLED (EMPLOYEE/SUBSCRIBER SIGNATURE AND DATE)

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

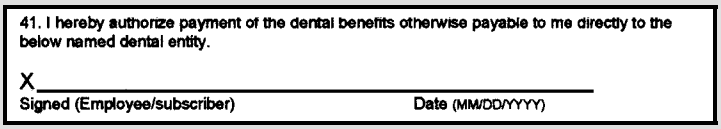
X_____
Signed (Patient/Guardian) Date (MM/DD/YYYY)

Not required.

BOX 40: EMPLOYER/SCHOOL

Not required.

BOX 41: UNTITLED (EMPLOYEE/SUBSCRIBER SIGNATURE AND DATE)



Not required.

BOX 42: NAME OF BILLING DENTIST

42. Name of Billing Dentist or Dental Entity

Enter the name of the Billing Provider or the name of the practice, even if a servicing provider performed the actual service.

Example:

42. Name of Billing Dentist or Dental Entity
John Doe, DDS

TIP:

The name of the practice is the DBA name, or the name under which you do business.

BOX 43: PHONE NUMBER

43. Phone Number
( )

Not required, but recommended.

BOX 44: PROVIDER ID

44. Provider ID #

Enter the Billing Provider's nine-digit Billing Provider ID number assigned by MaineCare.

Example:

44. Provider ID #
333333300

TIP:

Refer to your MaineCare enrollment letter for your Provider ID number.

BOX 45: DENTIST SOC. SEC. OR T.I.N.

45. Dentist Soc. Sec. or T.I.N.

Not required.

BOX 46: ADDRESS

46. Address

Not required.

BOX 47: DENTIST LICENSE

47. Dentist License #

Enter the license number of the dentist or other dental professional who provided the service. Not required but recommended.

Example:

47. Dentist License #
0001

ALERT:

The Maine Board of Dental Examiners issues a license number to each dental professional.

BOX 48: FIRST VISIT DATE OF CURRENT SERIES

48. First visit date of current series:

Not required.

BOX 49: PLACE OF TREATMENT

49. Place of treatment
☐Office ☐Hosp. ☐ECF ☐Other

Enter an X in the appropriate box for the place of treatment.

Select ECF (Extended Care Facility) if the service was in a Nursing Facility, Boarding Home, ICF/MR, Adult Family Home, or Private Non-Medical Institution.

Example:

49. Place of treatment
☐Office ☒Hosp. ☐ECF ☐Other

BOX 50: CITY

50. City

Not required.

BOX 51: STATE

51. State

Not required.

BOX 52: ZIP CODE

52. Zip Code

Not required.

BOX 53: RADIOGRAPHS OR MODELS ENCLOSED?

53. Radiographs or models enclosed?
☐Yes, How many?_____ ☐No

Not required.

BOX 54: IS TREATMENT FOR ORTHODONTICS?

54. Is treatment for orthodontics? ☐Yes ☐No
If service already commenced:
Date appliances placed _____ Total mos. of treatment remaining _____

Enter an X in the **Yes** or **No** checkbox. If Yes, also complete these fields:

Date appliance placed in – Enter the month, day and year the appliance was placed in 8-digit format MMDDYYYY.

Total mos. treatment remaining – Enter the number of months of treatment remaining.

Example:

54. Is treatment for orthodontics? ☒Yes ☐No
If service already commenced:
Date appliances placed 06212004 Total mos. of treatment remaining 4

BOX 55: IF PROSTHESIS, IS THIS INITIAL PLACEMENT?

55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No
If no, reason for replacement: _____
Date of prior placement: _____

Not required.

BOX 56: IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS?

56. Is treatment result of occupational illness or injury? ☐ No ☐ Yes
Brief description and dates_____

Enter an X in the appropriate **Yes** or **No** checkbox. If Yes is checked, complete the *Brief description and dates* field. Give a short description of the illness or injury, followed by the date of the illness or injury using 8-digit format (MMDDYYYY).

Example:

56. Is treatment result of occupational illness or injury? ☐ No ☒ Yes
Brief description and dates Fell onto machine 05132006

BOX 57: IS TREATMENT RESULT OF:

57. Is treatment result of: ☐ auto accident? ☐ other accident? ☐ neither
Brief description and dates_____

Enter an X in the auto accident? or other accident? checkbox.

If auto accident or other accident is checked, complete the *Brief description and date*s field. Give a short description of the accident, followed by the date of the accident using 8-digit format (MMDDYYYY)..

Example:

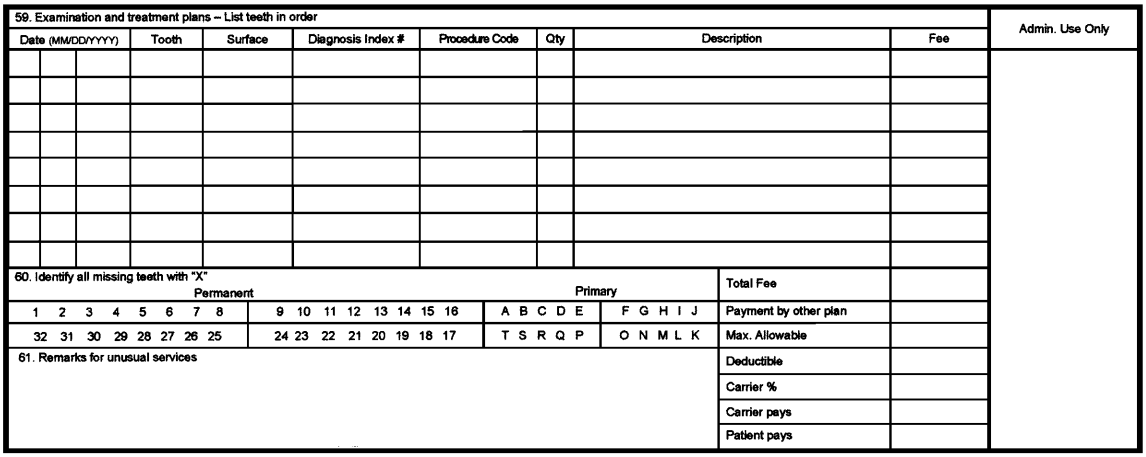
57. Is treatment result of: ☒ auto accident? ☐ other accident? ☐ neither
Brief description and dates Hit steering wheel 05142005

BOX 58: DIAGNOSIS CODE INDEX

58. Diagnosis Code Index (optional)
1._____ 2._____ 3._____ 4._____ 5._____ 6._____ 7._____ 8._____

Not required.

BOX 59: EXAMINATION AND TREATMENT PLANS – LIST TEETH IN ORDER



59. Examination and treatment plans – List teeth in order									Admin. Use Only
Date (MM/DD/YYYY)			Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

60. Identify all missing teeth with "X"																				Total Fee	
Permanent																Primary					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	Payment by other plan	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	Max. Allowable	
61. Remarks for unusual services																					Deductible	
																					Carrier %	
																					Carrier pays	
																					Patient pays	

See the following pages for instructions for completing all fields within Box 59.

Box 59
Date

BOX 59: DATE

Date (MM/DD/YYYY)		

Enter the month, day and year the service was performed using 8-digit format (MMDDYYYY).

Do not use dashes or hyphens.

Example:

Date (MM/DD/YYYY)		
06	21	2006

ALERT:

Please check the member's eligibility by calling 1-800-321-5557 option 8

Box 59
Tooth

BOX 59: TOOTH

Tooth

Enter the tooth number (1–32 for permanent teeth) or the tooth letter (A–T for primary teeth).

NOTE: For tooth numbers 1–9, **do not put a zero before the tooth number.**

For supernumerary tooth designations, please use the following:

Permanent dentition: Supernumerary teeth are identified by the numbers 51–82 (add 50 to each tooth number).
Example: tooth 32 would be supernumerary tooth 82.

Primary dentition: For supernumerary teeth (A–T), place the letter S after the letter of the primary tooth.
Examples: tooth A would be AS. Tooth Q would be QS.

NOTE: You may bill only one tooth per line.

Example:

Tooth
7

ALERT:
Do not put a zero before the tooth number.

Box 59 *Surface*

BOX 59: SURFACE

Surface

Enter the appropriate letter indicating the surface of the tooth that was restored:

O: occlusal
M: mesial
D: distal
B: buccal
L: lingual
F: facial
I: incisal

Example:

Surface
D

Box 59
Diagnosis

BOX 59: DIAGNOSIS INDEX

Diagnosis Index #

Complete this field only if the diagnosis is ANUG (Acute Necrotizing Ulcerative Gingivitis). If that is the diagnosis, enter ANUG.

Example:

Diagnosis Index #
ANUG

Box 59 *Code*

BOX 59: PROCEDURE CODE

Procedure Code

Enter the appropriate five-digit procedure code. All procedure codes start with the letter D.

NOTE: For 837 electronic dental transactions, under the Health Insurance Portability and Accountability Act (HIPAA), Current Procedural Terminology (CPT) modifiers are not allowed. For paper claims, you may use a CPT modifier. **Note:** See **Appendix A on Page 36** for modifier usage.

Example:

Procedure Code
D1111

MaineCare no longer accepts procedure codes that begin with a zero.

If billing with a modifier you must bill on a paper claim.

BOX 59: QTY

Qty

For each procedure code listed in the previous field (Box 59 Procedure Code), enter the number of services provided.

Be sure that the amount in the Box 59 Fee field reflects the quantity you enter here. (For a 2 in QTY, enter the dollar amount that reflects the charges for 2.)

You can avoid a duplicate claim error if you are using a billing code that is based on quadrants. For example, you may use the same code for services for Upper Right Quadrant and for Upper Left Quadrant. However, instead of listing the same code on two lines, each with a quantity of 1, enter that code on one line with a quantity of 2. Then, in the Fee field, be sure to double the amount charged.

With codes such as those for anesthesia services, you must use a 30-minute code and quantity of 1 on one line and a 15-minute code and quantity for each additional 15 minutes on a second line.

Example:

Qty
1

Box 59 *QTY*

ALERT:

Do not leave the QTY (Quantity) field blank.

Example:
Billing for one hour:

D9220 with quantity of 1 on the first line and

D9221 with quantity of 2 on the second line

Box 59 *Desc.*

BOX 59: DESCRIPTION

Description

Not required.

Box 59
Fee

BOX 59: FEE

Fee

Enter the Provider's usual and customary fee. Do not enter the MaineCare reimbursement rate.

The fee must reflect the number of segments of a procedure entered in the QTY field. (For a 2 in QTY, double the fee and enter that amount here.)

When a procedure code has been prior authorized and is listed as "By Report" in Chapter III of the *MaineCare Benefits Manual*, enter the prior authorized amount listed on your Prior Authorization letter. Be sure the units entered in QTY reflect the number of units allowed on the prior authorization.

Example:

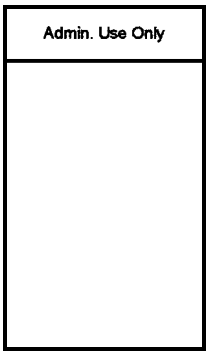
Fee
32.00


ALERT:

Please ensure that the amount of the prior authorization you enter is correct for each unit. This is important if the prior authorization was for more than one unit.

Box 59 *Admin.*

BOX 59: ADMIN. USE ONLY

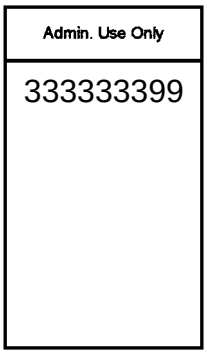


Enter the Servicing Provider ID number for the dentist, hygienist or denturist who performed the service. Refer to your MaineCare enrollment letter for Servicing Provider ID numbers. Servicing Provider numbers always end in 99.

A hygienist working in a dentist's office does not require a Servicing Provider ID number. However, any other hygienist, such as those under public health supervision, must enroll as a Servicing Provider and obtain a Servicing Provider ID number.

If you have not been assigned a Servicing Provider ID number, leave this field blank.

Example:



Box 59
Total Fee, Payment

BOX 59: TOTAL FEE

Total Fee	

Add all fees listed in the Fee column. Enter the total.

Example:

Total Fee	320.00

BOX 59: PAYMENT BY OTHER PLAN

Payment by other plan	

Enter the amount that insurance has paid for the service. If the insurance made no payment leave this box empty. You must submit the insurance company's explanation of benefits (EOB) with the claim.

Example:

Payment by other plan	80.00


ALERT:
If billing after other insurance you must attach an EOB therefore you must submit a paper claim.

Box 59 *Max.*

BOX 59: MAX. ALLOWABLE

Max. Allowable	

Not required.

BOX 59: DEDUCTIBLE

Deductible	

Not required.

BOX 59: CARRIER %

Carrier %	

Not required.

BOX 59: CARRIER PAYS

Carrier pays	

Not required.

Box 59 *Patient*

BOX 59: PATIENT PAYS

Patient pays	

If the Maine Department of Health and Human Services, Office of Integrated Access and Support (OIAS) issued you a spenddown letter for this patient, enter the dollar amount that is the patient's responsibility.

NOTE: The totals and dates of service on the spenddown letter must match those on this claim. Include a copy of the spenddown letter with this claim.

Example:

Patient pays	19.00

BOX 60: IDENTIFY ALL MISSING TEETH WITH "X"

60. Identify all missing teeth with "X"																					
	Permanent																Primary				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Not required.

BOX 61: REMARKS/ADJUSTMENTS

61. Remarks for unusual services

For **adjustments only**. If this is an adjustment, and not an original claim, enter the appropriate adjustment code:

7 to replace a previous claim, or

8 to void or to cancel a previous claim.

Also enter the original Transaction Control Number (TCN) in this field.

For assistance with adjustments, please call:

1-800-321-5557, Option 8

Example:

61. Remarks for unusual services

7 002005147084063000

BOX 62: SIGNED (TREATING DENTIST)

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

Enter the provider's name. The signature may be typed or stamped. An authorized person may sign on behalf of the treating dentist. The name must be the name of an actual person.

Do not use "signature on file."

License # is not required, but is recommended.

Enter the month, day and year this claim form was completed using 8-digit (MMDDYYYY).

Example:

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X John M. Doe 00001 06232006
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

ALERT:

The signature date must be on or after the last date of service.

BOX 63: ADDRESS WHERE TREATMENT WAS PERFORMED

63. Address where treatment was performed

Not required.

BOX 64: CITY

64. City

Not required.

BOX 65: STATE

65.State

Not required.

BOX 66: ZIP CODE

66. Zip Code

Not required.

APPENDIX A

MODIFIERS

Compliance with the Health Insurance Portability and Accessibility Act may require changes to the modifiers listed below. Providers will be notified of any changes by regular mail in the form of billing instructions.

A modifier provides the means whereby the reporting dentist can indicate that a service, which has been performed, has been altered by some specific circumstance, but not changed in its definition or code. Modifiers indicate situations such as:

1. A procedure was performed by more than one dentist.

2. A bilateral procedure was performed.

3. Unusual events occurred that made the procedure much more difficult or time consuming.

MaineCare will only accept the two-character modifiers listed on the following pages.

Some modifiers are meant to affect the fee payable for a particular service. These are called pricing modifiers. For example, the modifier used to indicate a surgical assist will allow payment of a percentage of the fee paid to the primary surgeon

Other modifiers do not affect the pricing of a particular code but they do describe more accurately the service being provided. These are called descriptive modifiers. For example, there is a modifier that identifies a service as a repeated procedure. This modifier more accurately defines the service but does not affect the level of reimbursement for the service.

MaineCare is able to accept up to two modifiers per code. It is believed that, in almost all circumstances, providers will be able to accurately describe a service by the use of the appropriate procedure code and up to two modifiers. Rarely, it may be necessary to use more than two modifiers to accurately define a service. In those instances, you are directed to use modifier "99", which indicates multiple modifiers. The use of modifier "99" will result in a manual review of the claim. This will delay payment since the automated processing of the claim will be interrupted. Providers are urged to reserve the use of modifier "99" for those situations in which a service can be properly reimbursed only by the use of three or more modifiers.

It should be noted that modifiers would be only used on a regular basis by oral surgeons. The general dental codes are specific enough to describe most treatments without the use of modifiers.

LIST OF ACCEPTED MAINECARE MODIFIERS FOR DENTISTRY

MODIFIER	DEFINITION
22	UNUSUAL SERVICE - The service provided is greater than that usually required for the listed procedure. A report will be required.
50	BILATERAL PROCEDURES - Some bilateral procedures are identified by distinct procedure codes. For those which are not, modifier "50" should be used to designate bilateral procedures which require a separate incision and which are performed at the same operative session. The first procedure is identified by the proper five-digit code; the second (bilateral) procedure is identified by the proper code, plus modifier "50." Incidental procedures should not be billed as bilateral procedures; use this modifier only when the second procedure adds significant time or complexity to the patient's care.
51	MULTIPLE PROCEDURES - When multiple procedures are performed at the same operative session, the major procedure should be identified by the appropriate code. The lesser procedure(s) should be reported by adding the modifier "51" to the appropriate procedure code. Incidental procedures should not be billed as multiple procedures; use this modifier only when the secondary procedure(s) adds significant time or complexity to the patient's care.
55	POST-OPERATIVE MANAGEMENT - Use this modifier to identify the need for post-operative services in addition to routine follow-up care. Post-surgical complications such as infection or relapse or a condition arising, which is unrelated to the surgery, are examples of when it is appropriate to bill for post-operative services.
56	PRE-OPERATIVE MANAGEMENT - Use this modifier to identify situations when one dentist or physician provides the exam and history at the time of a hospital admission and a second dentist or physician performs the surgery. The modifier should be added to the procedure code for the hospital admission. Group practice dentists are considered to be one dentist.
62	TWO SURGEONS - Use this modifier to identify circumstances when two surgeons (usually with different skills) participate in the management of a particular surgical procedure. Modifier "62" should be added to each of the surgeon's procedure codes.

LIST OF ACCEPTED MAINECARE MODIFIERS FOR DENTISTRY (cont.)

MODIFIER	DEFINITION
66	SURGICAL TEAM - Use this modifier to identify circumstances where highly complex procedures require the concomitant services of several surgeons. Each surgeon should add modifier "66" to the procedure codes used for reporting the services. Modifier "66" requires a special report to accompany the claim.
80	ASSISTANT SURGEON - Use this modifier to identify surgical assistant services at a major surgical procedure.
99	MULTIPLE MODIFIERS - Under certain circumstances three or more modifiers may be necessary to completely define a service. In such situations, modifier "99" should be added to the basic procedure and the applicable individual modifiers represented by "99" should be listed as a part of the written description of the service. Claims requiring modifier "99" must include a report.
76	REPEAT PROCEDURE - SAME DENTIST - Use this modifier to indicate that a service was repeated subsequent to the original procedure.
77	REPEAT PROCEDURE - ANOTHER DENTIST - Use this modifier to indicate that a procedure done by another dentist had to be repeated.
81	MINIMUM ASSISTANT SURGEON - Use this modifier to identify minimum surgical assistant services. Use this modifier in addition to modifier "80."

ADDITIONAL NOTES:

Modifier 22 must be used with D0150 when billing for the Supplemental Payment to General Dental Providers for Accepting New MaineCare Patients - See Chapter II, Section 25 of the MaineCare Benefits Manual for additional information and billing requirements for the supplemental payment.